

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005934	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/08/2015
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC,		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SUNNYBROOK CT SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was the 2015 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.</p> <p>Facility Number: 005934</p> <p>Survey Dates: 1/8/2015</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 16, 2015</p> <p>The hospice complied with 410 IAC 7-24, Retail Kitchen Sanitation Requirements, during their routine kitchen inspection.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE